DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 5/28/16

PRINTED: 04/13/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445408	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SODDY-DAISY HEALTH CARE CENTER	701 SEQUOYAH ROAD SODDY-DAISY, TN 37379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke detectors were located at least 3 feet from an air supply (NFPA 72, 2-3.5.1). The findings include: Observation and interview with the Maintenance Director, on 4/11/16 at 10:15 AM confirmed the smoke detectors in the front hall and hall by therapy were located too close to air supply. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during ~~the exit conference~~ on	K 051	K051 1.) The Director of Maintenance relocated smoke detector in the front hall on April 12, 2016, and relocated the smoke detector in the hall by therapy on April 25, 2016. 2.) The Maintenance Director audited the entire facility for proper compliance to ensure smoke detectors were located at least 3 feet from an air supply on April 12, 2016. 3.) The Maintenance Director was in-serviced by the administrator on ensuring smoke detectors were located at least 3 feet from an air supply on April 26, 2016. The preventative maintenance program will include auditing the smoke detectors to ensure that it is in compliance. 4.) Audits of the preventative maintenance program, which include the assessment of the smoke detectors in relation to air supply, will be performed by the Maintenance Director daily times 5 days and then weekly times 3 weeks and then monthly times 2 months and/or until 100% compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	NHA	4/27/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			The Director of Maintenance will report results of compliance with smoke detectors and their locations to air supply audits to the Quality Assurance Performance Improvement meeting for 3 months or until compliance is achieved. Members of the committee include Medical Director, Director of Nursing, Administrator and Assistant Director of Nursing, Staff Development, Social Services, Dietary Manager, Rehab Manager, Activity Director, Environmental and Unit Mangers.	5/16/16

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K 051	Continued From page 1 4/11/16.	K 051		
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire extinguishers were un-obstructed.(NFPA 10, 1-6.6) The findings include: Observation and interview with the maintenance director on 4/11/16 between 12:25 and 2:00 PM confirmed fire extinguishers were obstructed in dietary(2), by the MDS office and the extinguisher in the therapy corridor was hidden by an artificial shrub. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 4/11/16.	K 064	K064 1.) The Director of Maintenance on April 11, 2016, removed all obstructions to the fire extinguishers in the facility. 2.) The Maintenance Director audited all of the fire extinguishers throughout the facility to determine their compliance on April 12, 2016. 3.) The Maintenance Director was in-serviced by the Administrator on ensuring fire extinguishers were un-obstructed on April 26, 2016. The facility did a staff in-service that was completed on April 22, 2016, on ensuring fire extinguishers stay un-obstructed at all times. The preventative maintenance program will include auditing fire extinguishers to ensure that they are in compliance. 4.) Audits of the preventative maintenance program for ensuring fire extinguishers stay un-obstructed, will be performed by the Maintenance Director daily times 5 days and then weekly times 3 weeks and then monthly times 2 months and/or until 100% compliance.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10, 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridors in the means of egress	K 072		

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			The Director of Maintenance will report results of the fire extinguisher un-obstructed audits to the Quality Assurance Performance Improvement meeting for 3 months or until compliance is achieved. Members of the committee include Medical Director, Director of Nursing, Administrator and Assistant Director of Nursing, Staff Development, Social Services, Dietary Manager, Rehab Manager, Activity Director, Environmental and Unit Mangers.	5/16/16

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K 072	Continued From page 2 were maintained clear of all obstructions (NFPA 101- 7.1.10.2.1.) The findings include: Observation and interview with the Maintenance Director, during the facility tour on 4/11/16 between 9:00 AM and 11:30 AM confirmed the service corridor had beds stored and lifts/carts stored by the MDS office. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 4/11/16.	K 072	K072 1.) The Maintenance Director on April 11, 2016, removed all items that were obstructing or impediments to full instant use of egress in the identified area. 2.) The Maintenance Director audited the entire facility for obstruction or impediments to full instant use of egress to determine compliance on April 12, 2016. 3.) The Maintenance Director was in-serviced by the administrator on ensuring means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency on April 26, 2016. The facility did a staff in-service that was completed on April 22, 2016, on 8 foot egress path in all corridors. The preventative maintenance program will include auditing means of egress to ensure there in compliance with maintaining means of egress that are free of all obstructions or impediments to full instant use in the case of fire or other emergency.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire resistance rating of fire barriers. (NFPA 101, 8.3.5.1, 19.1.1.1.2) The findings include: Observation and interview with the maintenance director on 4/11/16 at 10:00 AM revealed the rated ceiling in the dishwashing room and in the kitchen area was damaged due to water leak. The ceiling was sagging and the tape was releasing. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 4/11/16.	K 130		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

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			4.) Audits of the preventative maintenance program, which include means of egress, will be performed by the Maintenance Director daily time 5 days and then weekly times 3 weeks and then monthly times 2 months and/or until 100% compliance. The Director of Maintenance will report results of sprinkler coverage audits to the Quality Assurance Performance Improvement meeting for 3 months or until compliance is achieved. Members of the committee include Medical Director, Director of Nursing, Administrator and Assistant Director of Nursing, Staff Development, Social Services, Dietary Manager, Rehab Manager, Activity Director, and Environmental.	5/16/16

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			K130 1.) The Maintenance Director contacted Lowes on April 15, 2016 and ordered the needed 5/8 sheetrock to replace the damaged areas identified. Identified areas will be repaired by May 15, 2016. 2.) The Maintenance Director audited the entire facility on April 12, 2016, for fire resistance barriers concerns. 3.) The Maintenance Director was in-serviced by the administrator on April 26, 2016, on maintaining the fire resistance rating of fire barriers. The preventative maintenance program will include auditing rooms to ensure there in compliance with fire resistance ratings of fire barriers. 4.) Audits of the preventative maintenance program, which include fire barriers, will be performed by the Maintenance Director daily time 5 days and then weekly times 3 weeks and then monthly times 2 months and/or until 100% compliance.	

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			The Director of Maintenance will report results of fire barriers audits to the Quality Assurance Performance Improvement meeting for 3 months or until compliance is achieved. Members of the committee include Medical Director, Director of Nursing, Administrator and Assistant Director of Nursing, Staff Development, Social Services, Dietary Manager, Rehab Manager, Activity Director, and Environmental.	5/16/16

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K 147	Continued From page 3 Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain electrical equipment. The findings include: Observation and interview with the maintenance director on 4/4/16 between 10:00 AM and 1:30 PM confirmed; 1. Bed in physical therapy was plugged into a power strip. 2. Two separate oxygen concentrators were plugged into power strips in physical therapy. 3. Power strips were plugged into each other in physical therapy behind the computer work station. 4. No 3' clear space in front of electrical panels in east and west wing electrical rooms and in washer room. 5. A ceiling mounted fluorescent light fixture had been removed in the laundry, and the wires were hanging exposed. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 4/11/16.	K 147	K147 1.) The Maintenance Director did the following things to resolve the outstanding items: (1) on April 11, 2016 removed all power strips and medical equipment was plugged into outlets (2) on April 18, 2016 red tape was placed at all electrical panels indicating the 3 foot barrier (3) on April 25, 2016, Ceiling light was replaced with a new 4 foot LED light purchased from Lowes on April 15, 2016. 2.) The Maintenance Director audited the entire facility to ensure compliance on April 12, 2016, for (1) power strips, (2) 3 foot clear space in front of electrical panels and (3) missing light fixtures with the wires exposed. 3.) The Maintenance Director was in-serviced by the administrator on National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 on April 26, 2016. The preventative maintenance program will include auditing rooms to ensure there in compliance with electrical equipment.	

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			4.) Audits of the preventative maintenance program, which include electrical equipment, will be performed by the Maintenance Director daily time 5 days and then weekly times 3 weeks and then monthly times 2 months and/or until 100% compliance. The Director of Maintenance will report results of electrical equipment audits to the Quality Assurance Performance Improvement meeting for 3 months or until compliance is achieved. Members of the committee include Medical Director, Director of Nursing, Administrator and Assistant Director of Nursing, Staff Development, Social Services, Dietary Manager, Rehab Manager, Activity Director, and Environmental.	5/16/16

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